DISCLOSURE FOR HOUSING WITH SERVICES ESTABLISHMENTS

State Form 49028 (8-98) / BAIS 0001

Date received stamp

The Disclosure for Housing with Services Establishments form is to be submitted to comply with IC 12-10-15. All sections, except Section 8, Optional Information, shall be fully completed. Section 8 is optional and provides information that you may wish to answer for potential residents who may use this form when looking for services.
A copy of the contract to be executed between the Housing with Services Establishment and the resident is the ONLY attachment that will be accepted in addition to the disclosure form. Therefore, it is important to concisely answer the questions on the form.

Indicate whether this is an original, update, or a renewal and enter date:

☐ Original Year _______________ ☐ Update Year _______________ ☐ Renewal Year _______________

SECTION 1 - ESTABLISHMENT INFORMATION

Name of facility:

On site manager's name:

Address line 1:

Address line 2:

City:	County:	ZIP code:
Telephone number:	FAX:	E-Mail:

Capacity (*number of apartments*):

Is the facility licensed as a residential care facility by the Indiana State Department of Health? ☐ Yes ☐ No

If Yes, license number:

Does the facility participate in the residential care program (RBA/ARCH)? ☐ Yes ☐ No

If Yes, enter the 4 digit ID:

Is your facility (*select one*):

☐ freestanding?
☐ part of a campus or complex? (*select all that apply*)
- ☐ part of an independent apartment complex?
- ☐ part of a nursing facility?
- ☐ part of an independent living building?
- ☐ part of a hospital?
- ☐ part of a continuing care facility?
- ☐ other: _____

SECTION 2 - OWNERSHIP / TYPE OF BUSINESS INFORMATION

Name of owner/company:

DBA:

Address line 1:

Address line 2:

City:	State:	ZIP code:
Telephone number:	FAX:	E-Mail:

Name of managing agent (*if not owner*):

Address line 1:

Address line 2:

City:	State:	ZIP code:
Telephone number:	FAX:	E-Mail:

Type of business (*select one*):

☐ For Profit ☐ Not For Profit ☐ Government ☐ Other (*please indicate*)

Business ownership (*select one*):

☐ Sole Owner ☐ Partnership ☐ Corporation ☐ Other (*please indicate*)

Month of the year that begins your fiscal (*accounting*) year?

SECTION 3 - CORPORATE OFFICERS

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS (*continued*)

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

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City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

Name:

Title: | Telephone number:

Address line 1:

City: | State: | ZIP code:

SECTION 5 - BASE RATE

Normal length of lease (*contract*):

☐ 1 month ☐ 3 months ☐ 6 months ☐ 1 year

☐ Other:

MONTHLY Per Person Base Rate Ranges for all that apply:

(*Note: If you convert a daily rate to a monthly rate please multiply your daily rate by 365 and then divide by 12.*)

			Semi-Private Occupancy:	Kitchenette:
Studio	From: $ _____	To: $ _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Optional
One Bedroom	From: $ _____	To: $ _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Optional
Two Bedroom	From: $ _____	To: $ _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Optional

☐ Additional fees may be required (*examples - admission fee, deposit fee, buy in fee, etc.*)

☐ Additional:_____

SECTION 6 - CONTRACT INFORMATION

What is the criteria and process used to determine who may continue to reside in your facility?

SECTION 6 - CONTRACT INFORMATION (*continued*)

Can the contract be modifed or terminated by the facility? ☐ Yes ☐ No If Yes, please explain under what conditions and the referral process.

Can the contract be modifed or terminated by the resident? ☐ Yes ☐ No If Yes, please explain under what conditions and the referral process.

Outline the steps that should be taken by the resident to register a complaint and the process for resolving the complaints.

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*check all that apply*)

MEALS: Extra meal fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Breakfast:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Lunch:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Dinner:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Snacks:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____

☐ Comments:

HOUSEKEEPING: Extra housekeeping fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

LAUNDRY: Extra laundry fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Bed/Bath Linens:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Personal:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____

☐ Comments:

PERSONAL ASSISTANCE: Extra personal assistance fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Dressing:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Toileting:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Transferring:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Mobility:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Bathing:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____
Eating:	☐ Included	☐ Not Included	☐ Extra Fee, From: $ _____	To: $ _____

☐ Comments:

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*con't*) (*check all that apply*)

BLOOD PRESSURE TAKEN: Extra blood pressure fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

EMERGENCY RESPONSE SYSTEM (ERS): Extra "ERS" fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

24-HOUR NURSING RESPONSE: Extra 24 hr. fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

LICENSED NURSING SERVICES AVAILABLE: Extra fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

MEDICATIONS: Extra medication fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Reminders: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Set-up: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Dispensing: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

ARRANGING OTHER MEDICAL SERVICES: Extra medical fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

ASSISTING WITH PERSONAL FUNDS: Extra fund fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

WANDER PROTECTION SYSTEM: Extra wander fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

ACTIVITIES: Extra activity fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Day Outings: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

In-House Activities: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Event Tickets: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*con't*) (*check all that apply*)

TRANSPORTATION: Extra transportation fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Facility Scheduled: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Unscheduled: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

UTILITIES: Extra utilities fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Heating: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Air Conditioning: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Electricity: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Water / Sewage: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Local Phone: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Cable TV: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☐ Comments:

Services not listed on this form that are either included or available for an additional fee:

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

Other Wellness / Health Related Services: ☐ Yes ☐ No If Yes, explain below:

SECTION 8 - OPTIONAL INFORMATION

Do you offer wheelchair accessible units and / or common areas (*check all that apply*)?
☐ Units / Apartments ☐ Common Areas

Does each apartment have fire sprinklers? ☐ Yes ☐ No

Are pets allowed? ☐ Yes ☐ No If Yes, please describe any additional fees or special conditions below:

Do you have a nursing home / health care center at the same location? ☐ Yes ☐ No

Are rehabilitation services available on site? ☐ Yes ☐ No If Yes, please identify:

SECTION 9 - INDIVIDUAL SUBMITTING THE FORM / MAILING INSTRUCTIONS		
Name of individual completing the form:	Title:	
Company / Affiliation:		
Address (*number and street*):		
City, state, ZIP code:		
Telephone number:	FAX:	E-Mail:
Verified by (*name*):	Title:	
Verified by (*signature*):		Date (*month, day, year*):

Send the completed form to the following address: (*Please do not FAX*)

MS 21
Assisted Living Disclosure
Bureau of Aging and In-Home Services
402 West Washington Street
Indianapolis, IN 46204

(*For questions call: 317-232-7947*)

DO NOT WRITE IN THIS SECTION
(*For Official Use Only***)**